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License No. _____
Checked By: _____
Approved By: _____

STATE OF MAINE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: Division of Licensing and Regulatory Services
Medical Facilities Unit
41 Anthony Avenue, #11 SHS
Augusta, ME 04333-0011

SUBJECT: Application for Renewal of a General/Specialty Hospital License

for the Period of: _____ to _____

FROM: _____
(Name of Hospital)

_____
(Street Address)

_____
(City) (Zip Code) (Telephone Number)

_____
E-Mail Address

Under the provisions of M.R.S.A. 1964, Title 22, S. 1811-1821, an act relating to licensing hospitals and related institutions in the State of Maine, application is hereby made to the Department of Human Services for a license or renewal of license to maintain and operate a General Hospital, as herein specified.

1. Applicant hospital is owned by: _____

   Operated by: _____

   Non-Profit: _____ Proprietary: _____

2. Chief Executive Officer: _____
   (Name) (Title)

3. Number of Beds by Level of Care: Location (if other than above)

Acute Hospital Beds	_____	_____
Designated Swing Beds	_____	_____
Bassinets	_____	_____
Skilled Nursing	_____	_____
Intermediate	_____	_____
Boarding Home	_____	_____
Acute Hospital Beds (not in use for over six months)	_____	_____

4. Check those health care services you propose to render. License will be limited to health care services and beds and bassinets applied for and approved. The first group of services relates to Daily Hospital Inpatient Services. Give number of beds by category. This total number of beds should agree with the totals on the first page. The second group of services relates to Ancillary Services which can be provided to either inpatients and/or outpatients.

DAILY HOSPITAL INPATIENT SERVICES

Acute Care	11X Private No. Beds	12X Semi-Priv. No. Beds	15X Ward No. Beds	16X Other No. Beds
1. Surgical				
2. OB/GYN				
3. Pediatric				
4. Psychiatric				
5. Medical				
6. Isolation				
7. Detoxification				
8. Alcoholic Rehab				
9. Other Acute Hospital Beds				
Acute Bed Totals				

(These totals combined with intensive care and Coronary Care Beds should equal acute beds under #3, Page 2.)

Skilled Nursing _____

Intermediate Care _____

Boarding Home Care _____

20X-INTENSIVE CARE	BEDS
1. General	_____
2. Surgical	_____
3. Medical	_____
4. Pediatric	_____
5. Psychiatric	_____
6. Neo Natal (Level II)	_____
7. Neo Natal (Level III)	_____
8. Burn Care	_____
9. Trauma	_____
10. Other (Specify)	_____

21X-CORONARY CARE	BEDS
1. Myocardial Infarction	_____
2. Pulmonary Care	_____
3. Cardiac Surgery	_____
4. Other (Specify)	_____

HOSPITAL ANCILLARY SERVICES

25X-Pharmacy _____

27X-Central Services _____

30X-Laboratory

1. Clinical _____
2. Anatomical Pathology _____
3. Hematology _____
4. Chemistry _____
5. Immunology _____
6. Bacteriology _____
7. Urine _____
8. Cytology _____
9. Other (Specify) _____

34X-Nuclear Medicine _____

32X-Radiology-Diagnostic _____

1. Angiocardiography _____
2. Computerized Tomography Scan - Head _____
3. Computerized Tomography Scan - Total Body _____
4. Mammography _____
5. Angiography _____
6. Other (Specify) _____

33X-Radiology - Therapeutic (Radiation Oncology)

1. Radiation Therapy _____
2. Cobalt Therapy _____
3. Radium Therapy _____

45X-Emergency Room _____

1. Diagnostic _____

2. Therapeutic _____

36X-Surgical Services

1. General Surgery _____

2. Organ Transplants _____

3. Open Heart Surgery _____

4. Neurosurgery _____

5. Orthopedic Surgery _____

6. Day Surgery _____

7. Other (Specify) _____

8. Laser Surgery (Equipment) _____

37X-Anesthesia

1. Anesthesia M.D. _____

2. Anesthesia CRNA _____

3. Acupuncture _____

38X-Blood Bank _____

39X-Oncology Service _____

41X-Respiratory Services _____

1. Inhalation Services _____

2. Hyperbaric Oxygen _____

3. Pulmonary Function _____

42x-Physical Therapy _____

43X-Occupational Therapy _____

44X-Speech Pathology _____

Level III _____

Level II _____

Level I _____

47X-Audiology _____

50X-Organized Outpatient Services _____

51X-Organized Clinics

1. Psychiatric _____

2. Surgery _____

3. Diabetic _____

4. ENT _____

5. Eye _____

6. OB/GYN _____

7. Orthopedic _____

8. Pediatric _____

9. Cardiology _____

10. Physical Medicine _____

11. Urology _____

12. Oncology _____

13. Ophthalmology _____

14. Other (Specify) _____

54X-Ambulance Service _____

56X-Medical Social Services _____

59X-Home Health Service _____

71X-Recovery Room _____

72X-Labor and Delivery _____

1. Labor Room _____
2. Delivery Room _____
3. LDR _____
4. LDP _____

73X-EKG _____

74X-EEG _____

76X-Nursery No. of Bassinets

1. Newborn (Level I) _____
2. Isolation _____

Total Bassinets _____
(Should agree with Total, Page 2)

77X-Ambulatory Care Center _____

80X-Renal Dialysis

1. Inpatient Hemodialysis _____
2. Inpatient Peritoneal Dialysis _____
3. Outpatient Hemodialysis _____
4. Outpatient Peritoneal Dialysis _____
5. Training Hemodialysis _____
6. Training Peritoneal Dialysis _____

5. Accrediations and Certifications

JCAHO: Date of last JCAHO Survey _____

Accredited for: _____ Years

A.O.A. Date of last A.O.A. Survey _____

Accredited for: _____ Years

Laboratory Accredited by C.A.P. _____ Date: _____

Number of years: _____

Laboratory Accredited by JCAHO _____ Date: _____

Number of years: _____

***** Please include the results of the Accredidation Survey if applicable *****

6. Has Hospital Charter, Constitution, or Bylaws been amended since last license application? _____

Date on which current Hospital Charter, Constitution, or Bylaws adopted by Governing Authority: _____.

7. Have the Medical Staff Bylaws been amended since last license application? _____

Date on which current Medical Staff Bylaws were approved by hospital Governing Authority: _____.

8. Use the space below to elaborate on any of the answers given above or to make any pertinent remarks. Refer to each item number to which comments pertain.

_____

_____

_____

_____

_____

90X-Other Services

1. Dental Services _____
2. Electromyography _____
3. Recreational Therapy _____
4. Ultrasound _____
5. Other Therapy (Specify) _____
6. Patient Education/Training _____
7. Podiatric Services _____

91X-Psychiatric/Psychological Services

1. Rehabilitation _____
2. Day Care _____
3. Individual Therapy _____
4. Group Therapy _____
5. Family Therapy _____
6. Bio Feedback _____
7. Testing _____
8. Electric Shock Treatment _____
9. Other (Specify) _____

List any other hospital facilities at locations other than the above addresses which are under the same ownership and governing authority:

_____

_____

_____

_____

I, _____, being duly authorized to assume responsibility for the conduct of the institution herein described, hereby file this application for a license and agree to assume responsibility for the institution, complying with all current regulations of the Department of Health & Human Services, as authorized by M.R.S.A., 1964, Title 22, §1811-1821, and amendments and additions thereto.

_____ _____

(Date) (Signature, Chief Executive Officer)

_____

(Address)

_____

(Address of CEO, if different from above)

FEES: The legislature has recently revised licensing fees to $40.00 for each acute bed and $26.00 for each skilled nursing bed within a facility. Your check or money order, made payable to Treasurer, State of Maine, should be mailed to:

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Medical Facilities Unit
41 Anthony Avenue, #11 SHS
Augusta, ME 04333-0011

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